EΥ
(X5)
PLETION DATE
AIE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 09/21/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMI 08/24	e survey Pleted 4/2012
NAME OF F	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIF FORD RD	P CODE	
ZIONSVI	LLE MEADOWS			VILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	Quality review of 4, 2012 by Bev 1	completed on September Faulkner, RN				

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Event ID: W9GJ11

Facility ID: 000538

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A DIJII DING	00	COMPLETED
	A. BUILDING				08/24/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R		FORD RD	
ZIONGVI	LLE MEADOWS			VILLE, IN 46077	
ZIONSVI	LLE MEADOWS		ZIONS	VILLE, IN 40077	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0164 SS=D	OF RECORDS The resident has privacy and conf	VACY/CONFIDENTIALITY the right to personal identiality of his or her			
	personal and clir	nical records.			
	medical treatment communications meetings of fami	includes accommodations, nt, written and telephone , personal care, visits, and ly and resident groups, but uire the facility to provide a each resident.			
	this section, the refuse the releas	ed in paragraph (e)(3) of resident may approve or se of personal and clinical dividual outside the facility.			
	personal and clir when the resider	ght to refuse release of nical records does not apply nt is transferred to another ution; or record release is			
	information conta records, regardle methods, except transfer to anoth law; third party p resident.	keep confidential all ained in the resident's ess of the form or storage when release is required by er healthcare institution; ayment contract; or the			
	interview, the far personal privacy eye drops to a coresident in the a deficient practic	vation, record review, and acility failed to provide valuring administration of ognitively impaired affected 1 of 10 and during medication #107]	F0164	F 164 Personal Privacy/Confidentiality of Reco This provider ensures the resident has the right to perso privacy and confidentiality of h or her personal and clinical records. What corrective action(s) will be accomplished for those residents found to have been affected by the	nal iis

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SUR	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETE	ED
		155620	B. WIN			08/24/20	12
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ORD RD		
ZIONOVI							
ZIONSVI	LLE MEADOWS			ZIONS	/ILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	_ CO	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					deficient practice? Resident	#	
	Findings include				107: the resident receives eye		
	Tillulings illicitude	•			drops in the privacy of his/her		
					room, or private area. Residen	t	
	1. On 8/21/12 at	t 9:22 A.M., Licensed			exhibited no signs/symptoms of	of	
	Practical Nurse [[LPN #1] was observed			psychosocial affect from the		
	administering ev	e drops, "Tears Natural			alleged deficient practice. The	:	
		eyes of Resident #107 in			Licensed Nurse received		
		•			re-education regarding resider	nt	
		ity room [an area located			privacy and confidentiality. H	ow	
	beside the nurse'	s station that was open			will you identify other resider	nts	
	without doors an	d visible from the			having the potential to be		
	hallwayl LPN #	‡1 did not ask Resident			affected by the same deficier	ıt 📗	
	• •				practice and what corrective		
	•	sion to give the eye drops			action will be taken?		
	_	om. In addition, Resident			Residents who receive eye dro		
	#107 did not con	nmunicate with LPN			have the potential to be affected		
	#107. Resident	#107 appeared alert;			by the alleged deficient practic		
		t verbally respond to LPN			Resident eye drop administrati		
	#1.	versuity respond to El IV			is completed in the privacy of t		
	#1.				resident's room or a private are	ea.	
					What measures will be put		
	During eye drop	administration, eight			into place or what systemic		
	residents were of	bserved in the activity			changes you will make to		
	room.	-			ensure that the deficient		
	100111.				practice does not recur?		
	00/21/12 + 1	20 D.M. D. 11 (#105)			Licensed nurses and Qualified		
		20 P.M., Resident #107's			Medication Aides were		
	record was revie	wed. Diagnoses			re-educated on privacy and		
	included, but we	re not limited to,			confidentiality regarding the administration of medications	,	
	-	agia, anxiety, and			August 28, 2012, and ongoing		
					Education was provided by the		
	depression.				Staff Development Coordinato		
					and Director of Nursing Service		
	_	ers," dated 8/1/12			Nursing and department		
	through 8/31/12,	included, but were not			supervisors monitor resident		
	limited to. "Tear	s Natural Balance			care, including medication		
	· ·	2 drops into both eyes 3			administration during daily		
		2 drops into both eyes 3			rounds, especially in common		
	times daily"				areas, i.e. dining and activity		
					rooms. Concerns are immedia	tely	

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	OF CORRECTION II	DENTIFICATION NUMBER: 155620	A. BUILDING B. WING	00 	COMPLETED 08/24/2012
ZIONSV	PROVIDER OR SUPPLIER		675 S F ZIONS	ADDRESS, CITY, STATE, ZIP CODE FORD RD VILLE, IN 46077	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	the Director of Nu the facility did not procedure on whe	P.M., in an interview, arsing [DoN] indicated thave a policy and re to give medications; cated staff should not an activity area.		corrected and reported to the Director of Nursing, or designed and re-education and/or disciplinary action is provided, needed. The Director of Nursing Services is responsible for compliance with medication administration. How will the corrective action(s) be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place. A Dignity and Privacy CQI to will be completed for 5 resident daily x 4 weeks, monthly x 2 at quarterly x 3, to ensure resident privacy and confidentiality is upheld. Through the audits, if a non compliance is noted, corrective action will be completed immediately. The audits will be reviewed by the committee and if a threshold on 95% compliance is not met an action plans will be developed ensure continued compliance.	as ing ur, e? ol ots nd nt any CQI f

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH DDIC	00	COMPLETED
		155620	A. BUILDING		08/24/2012
			B. WING	A DDDDGG GUTU GTATE TID GODE	
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
	= = . =			FORD RD	
ZIONSVI	LLE MEADOWS		ZIONS	VILLE, IN 46077	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	DROWINED S DI AN OF CODDECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F0225	483.13(c)(1)(ii)-(i	iii) (c)(2) - (4)			
SS=D	INVESTIGATE/F				
	ALLEGATIONS/				
		not employ individuals who			
		guilty of abusing,			
		streating residents by a			
		ave had a finding entered			
		rse aide registry concerning			
	abuse, neglect, r	mistreatment of residents or			
	misappropriation	of their property; and report			
	any knowledge it	has of actions by a court of			
	law against an e	mployee, which would			
		s for service as a nurse aide			
		taff to the State nurse aide			
	registry or licens	ing authorities.			
	•	ensure that all alleged			
		ng mistreatment, neglect, or			
		injuries of unknown source			
		ation of resident property			
	are reported imm				
		the facility and to other			
		dance with State law			
	•	ned procedures (including to			
	the State survey	and certification agency).			
	The facility must	have evidence that all			
	alleged violations				
	•	d must prevent further			
	•	while the investigation is in			
	progress.	write the investigation is in			
	progress.				
	The results of all	investigations must be			
		dministrator or his			
	•	esentative and to other			
		dance with State law			
		State survey and			
		ncy) within 5 working days of			
		if the alleged violation is			
		ate corrective action must			
	be taken.				
	Based on record	I review and interview, the	F0225	F 225 Investigate/Report	09/21/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
155620			B. WIN			08/24/2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	8			FORD RD	
ZIONSVI	LLE MEADOWS				VILLE, IN 46077	
					, in 40077	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	ì ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	DATE
	*	report an allegation of			Allegations/Individuals It is the practice of this provider to ens	
	alleged verbal at	ouse immediately to the			that all alleged violations involved	
	facility Adminis	trator, Director of			mistreatment, neglect, or abus	•
	Nursing, or Nurs	se Supervisor, and to			including injuries of unknown	
	State Agencies.	In addition the facility			source and misappropriation of	f
		the alleged violator			resident property are reported	
	_	iled to do a thorough			immediately to the administrat	
		ne deficient practice			of the facility and to other offic	ials
		esident reviewed for			in accordance with State law through established procedure	ne.
					(including the State survey and	
		egations in a sample of 24			certification agency). The	
	residents review	ed. [Resident #132]			facility ensures it has evidence	
					that all alleged violations are	
	Findings include	:			thoroughly investigated, and	
					prevents further potential abus	se
	1. On 8/20/12 a	t 10:45 A.M., tour was			while the investigation is in	
		censed Practical Nurse			progress. The results of all investigations is reported to the	Δ .
		at time, Resident #132			administrator or his designated	
		s being interviewable and			representative and to other	
		•			officials in accordance with Sta	ate
	_	h his activities of daily			law (including to the State surv	
	living.				and certification agency) within	
					working days of the incident, a	
	On 8/21/12 at 9:	30 A.M., Resident #132			if the alleged violation is verific	
	requested to spea	ak with an ISDH surveyor			appropriate corrective action is taken. What corrective	
	at 12:30 P.M., at	fter he returned from			action(s) will be accomplished	ed l
	physical therapy				for those residents found to	,
					have been affected by the	
	On 8/21/12 at 12:30 P.M., in an				deficient practice? Resider	nt#
	interview, Resident #132 indicated he had				132 – the resident allegation w	
					investigated during the annual	
	a concern regarding an incident that happened in early August, 2012, on a				survey process and reported to	
					the Indiana State Department Health. The licensed nurse wa	
	1	PN #9. He indicated that			suspended pending	20
	during breakfast	, LPN #9 intimidated him			investigation. The employee	
	by yelling in his	face and pointing at him			received re-education from the	
	at a close distance	ce. Resident #132			Director of Nursing Services	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BIII	LDING	00	COMPLETED	
		155620	B. WIN			08/24/2012
					ADDRESS, CITY, STATE, ZIP CODE	l
NAME OF F	PROVIDER OR SUPPLIER				FORD RD	
ZIONSVI	LLE MEADOWS				VILLE, IN 46077	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	indicated he fille	ed out a facility grievance			regarding resident rights and	
	form the same da	ay; however, he was not			customer service. Social Servi provided psychosocial suppor	
	happy with their	[the facility] response.			resident # 132 and the reside	
	Resident #132 de	enied fearing for his			has voiced no further concern	
		#9 or any other staff				
	1 *	licated the facility had				
		ot of his concerns just not			How will you identify other	
					residents having the potentia	al
	the one with LPN	N #9.			to be affected by the same	
					deficient practice and what	
		15 P.M., a verbal abuse			corrective action will be take	
	investigation reg	arding Resident #132			All residents have the potent	ıal
	was requested from	om the Executive			to be affected by the alleged deficient practice. During the	
	Director and the	Director of Nursing			course of the investigation, oth	ner
	[DoN].	S			residents were interviewed	
	[2011].				regarding interactions with	
	A "Dagidant/Eam	aile Canaama/Criarianaa			Licensed Nurse #9 and no	
		nily Concerns/Grievance			concerns were expressed.	
	Form" and addit				Resident allegations/concerns	;
	1 -	ent #132 was received			regarding	
	from the Directo	r of Nursing [DoN] on			abuse/neglect/misappropriatio	on of
	8/22/12 at 9:00 A	A.M.			funds/ISDH reportables are reported to the Administrator,	
					and/or designee and an	
	At that time, in a	in interview, the DoN			investigation is initiated	
		ility did not report the			immediately. Resident's	
		I or follow the facility			attending physician and	
		n policies and procedures			responsible party are notified	of
		•			any allegation of	
	for the reported grievance.				abuse/neglect/ISDH reportable guidelines. Employees nam	
					in an allegation are immediate	
	The grievance for	orm included, but was not			suspended, pending	'' [']
	limited to, "Resident Name: [Resident #132] Date of Concern: 8/4/12 Time				investigation. Corrective action	n
					_	The
		A.M Date Concerned			allegation is initially reported to	
		2 [no time] Concern			ISDH as soon as possible and	
		[marked] Resident			follow-up report is made within	
		-			days. Social Service provide	es
l	Executive Direct	tor Signature and Date:	1		psychosocial support to the	I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUILDING	00	COMPLETED
		155620	A. BUILDING B. WING		08/24/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R		FORD RD	
ZIONSVI	LLE MEADOWS			SVILLE, IN 46077	
	LLL IVILADOVVS				
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG		1 22
		[12] Nature of Concern:		resident, as needed. What	
	[LPN #9] yellin	g at me in the dining room		measures will be put into pla	
	standing 1 ft [fo	ot] away trying to		or what systemic changes you	ou
	intimidate me	this incident is not the		deficient practice does not	
	first"			recur? All staff re-education	n l
				was provided by the Staff	
	The other docur	nents included, but were		Development Coordinator and	
		*		Social Service Director related	d to
		vritten narratives from		the facility abuse policy and	
		d violator] and LPN #10		procedure on August 28, 2012	2,
	[weekend super	visor].		and ongoing. The facility	.
				conducts Criminal Background checks upon hire and only the	
	A written narrat	ive dated 8/4/12, no time,		prospective employees withou	
	from LPN #9, ir	ncluded, but was not		criminal history background, p	
	limited to, "[Res	sident #132] was in the		company policy, are hired.	
		Room yelling at staff, staff		Employees are educated by S	Staff
	'	concern, he stated staff		Development Coordinator	
		ted with him passing		regarding the	
				abuse/Neglect/misappropriation	
		ed to yell and used		SDH reportable guidelines po and procedure, including	licy
		f stating he pays everyone		reporting any allegation of abo	ıse
		aff asked [Resident #132]		to the administrator and/or	
	if he would like	breakfast in his room		designee, upon hire, and no le	ess
	[sic] he stated n	o [other] residents in		than annually, and as needed	
	dining room wa	nted staff to escort him		Employees were re-educated	
	[Resident #132]	out"		Staff Development Coordinate	or
	,			on the facility Concern and Grievance Policy and Procedu	ıre
	A written narrat	ive, no date or time, from		on August 28, 2012, and	ui c
		ded, but was not limited		ongoing. Resident/Family	
				concern forms are located at	
	'	8/4/12 [no time] I was		nursing units and the receptio	nist
	_	t [Resident #132] wanted		desk to ensure residents and	
		lk to me about dietary		families have an opportunity to	
	staff he told m	ne that he did not receive		voice their concerns, including	
	what he had ord	ered today, but was tired		any allegation of abuse and/o neglect. The Administrator is	'
	of not getting se	erved first I told him I		notified of allegations of	
	1 -	dietary situation He		abuse/neglect immediately.	
	I	•	1	- ·	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					00	(X3) DATE S COMPLI	
		155620	A. BUII B. WIN	LDING		08/24/	
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ORD RD		
ZIONSVI	LLE MEADOWS			ZIONS\	/ILLE, IN 46077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
1710		then yelled my name [as		1110	The Administrator is responsib		DITTE
		aving his room] and			to monitor compliance with the	;	
	stated I want to t	ell you something else			Abuse Policy and Procedure Program as well as the overall		
	He [Resident #1]	32] stated that a nurse			investigative process regarding		
	' '	lled at him and that he			abuse allegations. How will		
		eck into it He stated			the corrective action(s) be monitored to ensure the		
		e dinning [sic] room and			deficient practice will not rec	ur,	
		ng staff that he wanted to			i.e., what quality assurance		
		He stated the nurses [sic]			program will be put into plac The Abuse Prohibition and	e?	
		d yelling at him in a I asked him if he was			Investigation CQI tool will be		
	1	id no, so I asked has this			utilized with 10 staff members		
		you before and he said			weekly x 4, 10 staff members monthly x 2 and 10 staff		
		ed if he felt threatened			members quarterly x 3. The		
	· ·	, but she [LPN #9] had no			audits will be reviewed by the		
		ne I asked him if he			committee and if a threshold o 100% compliance is not met,	f	
	would like to fill	out an orange form			action plans will be to ensure		
	[facility grievand	ce form] and he said yes			continued compliance.		
		ld talk to the staff and					
	_	im I did go talk to the					
		who stated that he was					
	'	ring at the staff and					
	hitting the table						
	_	LPN #9] stated that she he needed to calm down					
		at the staff and res [sic]					
		s very rude but did stop					
		ed down and she thought					
	everything was f	-					
	On 8/23/12 at 10	0:05 A.M., Resident					
	#132's record wa	s reviewed. Diagnoses					
	· ·	re not limited to, anxiety,					
	depressive disord	der, and cerebrovascular					

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	of Correction identification number: 155620	(X2) MULTIPLE CO. A. BUILDING B. WING	00 	(X3) DATE COMPI 08/24	LETED
	PROVIDER OR SUPPLIER LLE MEADOWS	675 S F	ODDRESS, CITY, STATE, ZIP COD ORD RD /ILLE, IN 46077	E	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	A "Resident Progress Notes," dated 8/4/12 at 8:30 A.M., included, but was not limited to, "Staff Certified Nursing Assistant [CNA] #11 informed writer [LPN #9] that resident [Resident #132] was yelling and cursing at her because she did not give him coffee first. Writer asked resident to calm down and stop yelling because there are other residents in the dining room. Resident continued to yell, curse, and pointing his finger Writer informed resident that this behavior is not tolerated" A "Resident Progress Notes," dated 8/4/12 at 1:44 P.M., included, but was not limited to, "This writer [LPN #12] made aware by nursing staff that res [sic] yelling and using profanity in the dining room this am [sic] during breakfast Requested to speak with management Management [weekend supervisor LPN #10] made aware of res [sic] request" On 8/23/12 at 10:45 A.M., in an interview, the Executive Director indicated LPN #9 was suspended from work on 8/23/12 and the facility was doing a thorough investigation of the incident regarding Resident #132. In addition, the Executive Director was not				

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620			LDING	NSTRUCTION 00	(X3) DATE COMPL 08/24	ETED
	PROVIDER OR SUPPLIER		p. wiiv	STREET A 675 S F	DDRESS, CITY, STATE, ZIP CODE ORD RD //ILLE, IN 46077	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	made aware of the abuse.	ne allegation of verbal					
	the incident with allegation of versuspend the allegation the incident. The abuse polici included, but we Abuse: defined written, or gestur willfully include derogatory terms families Examare not limited to things to frighter telling a resident able to see his/he scolding and/or svoice tone All must be reported Director immediate terminember implications.	Resident #132 as an bal abuse and did not ged violator [LPN #9] at t #132 notified staff of to residents or all t #132 notified staff of the use of oral, red language that the staff and to their ples would include, but to the estation the staff or the entative within 24 hours allure to report will result extion, up to and including the nation Any staff ted in the alleged abuse from the facility at once					
	investigation is o	suspended until an completedThe cor will report all unusual					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		155620	B. WING		08/24/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
ZIONSVI	LLE MEADOWS			FORD RD VILLE, IN 46077	
				T +0077	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		nich include abuse, within			
	1	covery, to the Long Term			
		f the Indiana State			
	Department of l				
	Department of I	Teartii			
	3.1-28(c)				
	J.1-20(0)				

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Event ID: W9GJ11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D.		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155620				08/24/2012	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ZIONOVII	LLE MEADOWS				ORD RD		
ZIONSVII	LLE MEADOWS			ZIONS	VILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0226 SS=D	ETC POLICIES The facility must of written policies are mistreatment, new residents and mister property. Based on record facility failed to grievance as an afollow their policies related to reportific Executive Direct	develop and implement and procedures that prohibit glect, and abuse of sappropriation of resident review and interview, the identify a resident allegation of abuse and cies and procedures and procedures and immediately to the tor, failed to do a gation, and failed to	F02	26	F 226 Develop/Implement Abuse/Neglect, Etc. Policies is the practice of this provider develop and implement writter policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident	1	09/21/2012
		_			property. What corrective		
	_	member from work			action(s) will be accomplishe	ed	
	during the invest	figation. [Resident #132]			for those residents found to		
	Findings include				have been affected by the deficient practice Resident 132 – the resident allegation winvestigated during the annual	/as	
		t 10:45 A.M., tour was			survey process and reported to		
		censed Practical Nurse			the Indiana State Department		
		at time, Resident #132			Health. The licensed nurse wa	as	
	was identified as	being interviewable and			suspended pending investigation. The employee		
	independent with	n his activities of daily			received re-education from the	;	
	living.				Director of Nursing Services		
	-				regarding resident rights and		
	On 8/21/12 at 9::	30 A.M., Resident #132			customer service. Social Servi		
		ak with an ISDH surveyor			provided psychosocial support		
	• •	ter he returned from			resident # 132 and the resider has voiced no further concerns		
	physical therapy				Tida voiced no futther concerns	.	
	pirysical ulerapy	•					
	On 8/21/12 at 12				How will you identify other residents having the potentia	ıl	
	•	ent #132 indicated he had			to be affected by the same		
	a concern regard	ing an incident that			deficient practice and what	_	
					corrective action will be take	n?	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COM		COMPLETED
		155620	B. WING		08/24/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		FORD RD	
ZIONSVILLE MEADOWS			VILLE, IN 46077		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		ly August, 2012, on a		All residents have the potent to be affected by the alleged	ial
	Saturday with L	PN #9. He indicated that		deficient proactice. During the	<u> </u>
	during breakfas	t, LPN #9 intimidated him		course of the investigation, ot	
	by yelling in his	face and pointing at him		residents were interviewed	
	at a close distan	ce. Resident #132		regarding interactions with	
	indicated he fill	ed out a facility grievance		Licensed Nurse #9 and no	
		lay; however, he was not		concerns were expressed.	
		r [the facility] response.		Resident allegations/concerns	6
		lenied fearing for his		regarding abuse/neglect/misappropriation	on of
		•		funds/ISDH reportables are	
	1	N #9 or any other staff		reported to the Administrator,	
		dicated the facility had		and/or designee and an	
		ot of his concerns just not		investigation is initiated	
	the one with LP	N #9.		immediately. Resident's	
				attending physician and	
	On 8/21/12 at 3	:15 P.M., a verbal abuse		responsible party are notified any allegation of	OI
	investigation re	garding Resident #132		abuse/neglect/ISDH reportable	e
		rom the Executive		guidelines. Employees nam	
	_	Director of Nursing		in an allegation are immediate	
	[DoN].	o Bricetor of reading		suspended, pending	
	[D011].			investigation. Corrective actio	
	A "Dogidan4/Da	mile. Compound/C-i		· · · · · · · · · · · · · · · · · · ·	The
		mily Concerns/Grievance		allegation is initially reported to ISDH as soon as possible and	
		tional documents		follow-up report is made within	
		ent #132 were received		days. Social Service provid	
		or of Nursing [DoN] on		psychosocial support to the	
	8/22/12 at 9:00	A.M.		resident, as needed. What	
				measures will be put into pla	
	At that time, in	an interview, the DoN		or what systemic changes y	ou
	indicated the fac	cility did not report the		will make to ensure that the	
		H or follow the facility		deficient practice does not recur? All staff re-educatio	,
		on policies and procedures		was provided by the Staff	"
	for the reported			Development Coordinator and	<u> </u>
	ioi die reported	grievance.		Social Service Director related	
	The control of	anne in de de d. t		the facility abuse policy and	
	_	orm included, but was not		procedure on August 28, 2012	2,
	limited to, "Res	ident Name: [Resident		and ongoing. The facility	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED	
		155620	A. BUILDING B. WING		08/24/2012	
				ADDRESS, CITY, STATE, ZIP CODE	L	
NAME OF I	PROVIDER OR SUPPLIE	R		FORD RD		
ZIONSVI	LLE MEADOWS			VILLE, IN 46077		
ZIONSVILLE IVIEADOWS			VILLE, IIV 40077			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	· ·	DATE	
	_	Concern: 8/4/12 Time		conducts Criminal Backgroun		
	of Concern: 8 t	o A.M Date Concerned		checks upon hire and only the prospective employees without		
	Received: 8/5/1	2 [no time] Concern		criminal history background, p		
	Received from:	[marked] Resident		company policy, are hired.		
	Executive Direc	etor Signature and Date:		Employees are educated by S	Staff	
		/12] Nature of Concern:		Development Coordinator		
	1 - 0	g at me in the dining room		regarding the		
	1	ot] away trying to		abuse/Neglect/misappropriation SDH reportable guidelines po		
		this incident is not the		and procedure, including	licy	
		this incident is not the		reporting any allegation of abo	ıse	
	first"			to the administrator and/or		
				designee, upon hire, and no le	ess	
		ments included, but were		than annually, and as needed		
	not limited to, v	vritten narratives from		Employees were re-educated	-	
	LPN #9 [alleged	d violator] and LPN #10		Staff Development Coordinate	or	
	[weekend super	visor].		on the facility Concern and Grievance Policy and Procedu	ıre	
		-		on August 28, 2012, and	ile	
	A written narrat	ive, dated 8/4/12, no time,		ongoing. Resident/Family		
		ncluded, but was not		concern forms are located at		
	•	sident #132] was in the		nursing units and the receptio	nist	
	_	-		desk to ensure residents and		
	1 -	Room yelling at staff, staff		families have an opportunity to		
		concern, he stated staff		voice their concerns, including any allegation of abuse and/o		
		ted with him passing		neglect. The Administrator is	'	
		ied to yell and used		notified of allegations of		
		f stating he pays everyone		abuse/neglect immediately.		
	[sic] salary sta	aff asked [Resident #132]		The Administrator is responsil		
	if he would like	breakfast in his room		to monitor compliance with the	e	
	[sic] he stated n	o [other] residents in		Abuse Policy and Procedure		
		nted staff to escort him		Program as well as the investigative process regarding		
	[Resident #132]			abuse allegations. How wil		
	[[1100100110 // 102]			the corrective action(s) be		
	A written nerrot	ive, no date or time, from		monitored to ensure the		
				deficient practice will not red	cur,	
		ded, but was not limited		i.e., what quality assurance		
		8/4/12 [no time] I was		program will be put into place	e?	
	told by staff tha	t [Resident #132] wanted		The Abuse Prohibition and		

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AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII		00	COMPLETED	
	155620	B. WIN			08/24/2012	
NAME OF PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
ZIONSVILLE MEADOWS			675 S FORD RD ZIONSVILLE, IN 46077			
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION
	LSC IDENTIFYING INFORMATION)		TAG			DATE
staff he told me what he had order of not getting ser would look into a [Resident #132] the LPN #10 was lead stated I want to the He [Resident #132 [LPN #9] had ye wanted me to che that he was in the that he was telling be served first came over started threatening way scared and he said ever happened to no, so then I asked and he stated no, right to correct me would like to fill [facility grievance I told him I would follow up with him the light properties of the p	LPN #9] stated that she he needed to calm down at the staff and res [sic] s very rude but did stop ed down and she thought			Investigation CQI tool will be utilized with 10 staff members weekly x 4, 10 staff members monthly x 2 and 10 staff members quarterly x 3. The audits will be reviewed by the committee and if a threshold of 100% compliance is not met, action plans will be to ensure continued compliance.		

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	of Correction identification number: 155620	(X2) MULTIPLE CC A. BUILDING B. WING	00 	COMPI 08/24			
	PROVIDER OR SUPPLIER LLE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	On 8/23/12 at 10:05 A.M., Resident #132's record was reviewed. Diagnoses included, but were not limited to, anxiety, depressive disorder, and cerebrovascular disease. "Resident Progress Notes," dated 8/4/12 at 8:30 A.M., included, but was not limited to, "Staff Certified Nursing Assistant [CNA] #11 informed writer [LPN #9] that resident [Resident #132] was yelling and cursing at her because she did not give him coffee first. Writer asked resident to calm down and stop yelling because there are other residents in the dining room. Resident continued to yell, curse, and pointing his finger Writer informed resident that this behavior is not tolerated" A "Resident Progress Notes," dated 8/4/12 at 1:44 P.M., included, but was not limited to, "This writer [LPN #12] made aware by nursing staff that res [sic] yelling and using profanity in the dining room this am [sic] during breakfast Requested to speak with management Management [weekend supervisor LPN #10] made aware of res [sic] request" On 8/23/12 at 10:45 A.M., in an interview, the Executive Director						
	indicated LPN #9 was suspended from						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620		LDING	NSTRUCTION 00	(X3) DATE COMPL 08/24/	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	doing a thorough incident regarding addition, the Execute interim Execute made aware of the abuse. The facility did to the incident with	and the facility was a investigation of the ag Resident #132. In secutive Director indicated utive Director was not a allegation of verbal not thoroughly investigate. Resident #132 as an bal abuse and did not					
	suspend the alleg	ged violator [LPN #9] at t #132 notified staff of					
	included, but we Abuse: defined written, or gestur willfully include derogatory terms families Example are not limited to things to frighter telling a resident able to see his/he scolding and/or sevoice tone All must be reported Director immediates of the report Fain disciplinary and	es and procedures re not limited to, "Verbal as the use of oral, red language that s disparaging and s to residents or their ples would include, but b: threats of harm, saying a resident, such as that he/she will never by er family again; or speaking to them in harsh abuse allegations/abuse to the Executive ately, and to the entative within 24 hours ailure to report will result etion, up to and including mation Any staff					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
III.DIDIII		155620		LDING		08/24/2012		
			B. WIN		DDRESS, CITY, STATE, ZIP CODE	L "		
NAME OF P	ROVIDER OR SUPPLIER	L Comment			ORD RD			
	LLE MEADOWS		ZIONSVILLE, IN 46077					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
1710		ted in the alleged abuse		0	•		ZIIIZ	
		from the facility at once						
		suspended until an						
	investigation is c	-						
		tor will report all unusual						
		ich include abuse, within						
		overy, to the Long Term						
	Care Division of	Tthe Indiana State						
	Department of H	lealth"						
	3.1-28(a)							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155620	B. WIN			08/24/	2012
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			675 S F	ORD RD		
ZIONSVII	LLE MEADOWS				/ILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0323 SS=E	483.25(h) FREE OF ACCID	FNT					
00-L		RVISION/DEVICES					
	The facility must of	ensure that the resident					
		ains as free of accident					
	· ·	sible; and each resident					
	· ·	e supervision and es to prevent accidents.					
		ation, interview, and	F03	23			09/21/2012
		ne facility failed to ensure					\$5, 2 1, 2 012
	•	azardous chemicals were					
	1	residents. This deficient			F 323 FREE OF ACCIDENT		
		potential to affect 9 of 24			HAZARDS/SUPERVISION/DE		
		sided on a Memory Care			CES It is the practice of this provider to ensure that the		
		•			resident environment remains	as	
	unit (a locked/se				free of accident hazards as is		
	Alzheimer's/dem				possible; and each resident		
	_	endently in a wheelchair			receives adequate supervision		
		ents on B Hall who were			and assistance devices to prevaccidents. What correcti		
	confused and up	ad lib (independently).			action(s) will be accomplishe	-	
					for those residents found to	·u	
	Findings include	:			have been affected by the		
					deficient practice? Cottage	2:	
	On 8/20/12 at 10	:35 A.M., a tour of			Hazardous items located on th	е	
	Cottage 2 (the lo	cked/secured			linen cart on Cottage 2 were		
	Alzheimer's/dem	entia unit) was initiated			removed and secured immediately. B Wing:		
		PN #3 indicated there			Hazardous items found in the		
		idents on this unit who			unlocked room on B Wing were	е	
	` '	endently in wheelchairs.			immediately removed and		
	amounated macp	endendy in whoolehalis.			secured, and a keypad lock wa		
	On 8/20/12 of 10	:35 A.M., a tour of B			installed. How will you ident	tify	
		d with LPN #8. LPN #8			other residents having the	_	
					potential to be affected by the same deficient practice and	t	
		vere four (4) residents on			what corrective action will be	.	
		re confused and up ad lib			taken? Residents who are	•	
	(independently).				confused and up independently	у	
					have the potential to be affected	ed	
					by the alleged deficient practic	e.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SUF		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETE	
		155620	B. WIN	IG		08/24/20	12
NAME OF I	PROVIDER OR SUPPLIEI		•	STREET .	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	FRO VIDER OR SUFFLIE	X.		675 S F	FORD RD		
ZIONSVI	LLE MEADOWS			ZIONS	VILLE, IN 46077		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	DROWING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		OMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	ATE.	DATE
	On 8/23/12 at 9:	20 A.M., the tour of the			The Unit supervisors monitor		
	environment wa	s initiated with the			resident common areas to en		
	Assistant Execu	tive Director, the			hazardous products are secu	red	
		pervisor, and the			and do not come into direct contact with residents. Wh	at	
ı		keeping Supervisor in			measures will be put into pl		
ı	attendance.	sceping Supervisor in			or what systemic changes y		
	attendance.				will make to ensure that the		
ı	0 0/22/12 40	55 4 3 6 1 1 1			deficient practice does not		
		55 A.M., an unlocked			recur? Staff was re-educate	ed	
		was found to contain			by the Staff Development		
		bottles of "McKesson			Coordinator regarding hazard		
	Wash for Hair and Body." The labels of				items on August 28, 2012, ar ongoing, The dementia unit		
	each bottle indic	cated this product was for			nursing unit environments are		
	"External use on	nly. Discontinue if			monitored daily by supervisor		
	irritation occurs	. Avoid contact with			and department heads. Shou		
	eyes. In case of	eye contact flush with			noncompliance be noted,		
	water and contact				corrective action will be taken		
		I Jan H			immediately. The Director of Nursing Services is responsite		
	In an interview a	at this time the			for compliance with	ne	
		pervisor indicated he			environmental hazards. Ho	w	
		tall a coded lock on the			will the corrective action(s)	be	
	door to this roor				monitored to ensure the		
		п.			deficient practice will not re	cur,	
	41				i.e., what quality assurance		
		e unlocked room was a 4			program will be put into pla	ce?	
		'McKesson Moisturizing			The Care Rep Daily rounds Checklist will be utilized on a	.	
		n." The label indicated			units daily x 30 days, monthly		
	•	s for "External use only.			and quarterly x 3. The audits		
	Discontinue if in	ritation occurs. Avoid			be reviewed by the CQI		
	contact with eye	es. In case of eye contact			committee and should a thres		
	flush with water	and contact a physician."			of 95% compliance not be me		
					action plans will be developed ensure continued compliance		
	Also in this sam	e unlocked room were			Should continued compilation		
ı		e tubes of "Smith &					
ı		Protective Ointment" that					
ı	_						
ı	contained a labe	l indicating this product					

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	of correction identification number: 155620	(X2) MULTIPLE CON A. BUILDING B. WING	00 	COMPI 08/24	LETED	
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
	was for "External use only. Avoid contact with the eyes. Keep out of reach of children. If swallowed get medical help or contact a Poison Control Center immediately."					
	On 8/23/12 at 10:45 A.M., a linen cart was observed outside of resident room #525 on Cottage 2. This cart contained clean linens and a 300 ml bottle of "Array perineal wash" that contained a label indicating, "Keep out of reach of children. For external use only."					
	Also in the linen cart was an 11 ounce can of "McKesson Medi-Pak shaving cream" with a label indicating, "Contents under pressure. Keep out of reach of children."					
	In an interview at this time, the Memory Care Facilitator indicated he would have the nurse secure the items.					
	3.1-45(a)(1)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
		155620	B. WIN			08/24/	2012
	PROVIDER OR SUPPLIER			675 S F	ADDRESS, CITY, STATE, ZIP CODE FORD RD /ILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0329 SS=D	from unnecessary drug is any drug of dose (including of dose (including of excessive duration monitoring; or with for its use; or in the consequences where we should be reduce combinations of the sased on a compresident, the facility residents who had drugs are not given antipsychotic drug treat a specific condocumented in the residents who use receive gradual displayed behavioral interversidents who use receive gradual displayed in the drugs. Based on intervity facility failed to was checked price blood pressure in follow a physicial medication for syparameters, for 1	DRUGS rug regimen must be free y drugs. An unnecessary when used in excessive uplicate therapy); or for in; or without adequate hout adequate indications ne presence of adverse nich indicate the dose d or discontinued; or any he reasons above. orehensive assessment of a ity must ensure that we not used antipsychotic en these drugs unless g therapy is necessary to ondition as diagnosed and e clinical record; and e antipsychotic drugs ose reductions, and entions, unless clinically in an effort to discontinue ew and record review, the ensure a blood pressure for to administering a nedication, in order to an's orders to "Hold" the pecified blood pressure of 2 residents who had sample of 24 residents dent #81]	F03	29	F 329 Drug Regimen is Free From Unnecessary Drugs It is the practice of this provider to ensure that each resident's drug regimen is free from necessary drug: An unnecessary drug is any drug whused in excessive dose (including duplicate therapy): or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.		09/21/2012

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620		A. BUI	LDING	00	(X3) DATE COMPL 08/24/	ETED	
		100020	B. WIN		A DED DE COMPANION DE COMP	00/24/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE FORD RD		
ZIONSVI	LLE MEADOWS				VILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		on 8/20/12 at 10:35 A.M.,					
		ted Resident #81 had a					
		The resident was					
		wheelchair for mobility			What corrective action(s) wi	II	
	most of the time	, but was able to			be accomplished for those		
	ambulate.				residents found to have bee affected by the deficient	n	
	The clinical reco	ord for Resident #81 was			practice?		
	reviewed on 8/2	1/12 at 10:30 A.M.					
	Diagnoses includ	ded, but were not limited					
	•	ry disease with stents,			Resident # 81's blood pressu	re is	
	•	high cholesterol],			monitored per MD order and		
	'' '	pertension [high blood			MD is notified if the systolic b pressure is less than 100, or		
	pressure].				heart rate is less than 60.	u iC	
	F1.						
	On 7/9/12, the pl	hysician gave an order for					
	Metoprolol [a Bo	eta Blocker medication					
	used to treat hyp	ertension, angina,					
	congestive heart	failure] 25 mg.			How will you identify other		
	[milligrams]1/2	2 tablet daily, "Hold if			residents having the potent	al	
	systolic blood pr	ressure is less than 100, or			to be affected by the same deficient practice and what		
	heart rate less th	an 60. Notify M.D. if			corrective action will be take	en?	
	systolic blood pr	essure is greater than					
	150." The medic	cation was scheduled to					
	be given at 9:00	A.M. daily.			All regidents with above; :	rdoro	
					All residents with physician of for blood pressure parameter		
	On 8/22/12 at 9:	30 A.M., the August,			have the potential to be affect		
	2012 M.A.R. [M	ledication Administration					
	Record] was rev	iewed. The order for the					
	Metoprolol was	listed, with a			All residents with blood press	ure	
	hand-written not	ation for the "Hold"			parameters have been identif		
	parameters. The	ere were no blood			and reviewed by attending		
	pressure or heart	rate vital signs			physician, or designee. Resignee.	dent	
	documented on t	he M.A.R.			plans of care and medication		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		155620	B. WIN			08/24/2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹			ORD RD	
ZIONSVI	LLE MEADOWS		ZIONSVILLE, IN 46077			
(X4) ID		TATEMENT OF DEFICIENCIES			,	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
					administration records were	
	I., i	ot that time D.N. 46			updated, as needed.	
		at that time, R.N. #6			'	
		ood pressures and heart				
		one because they was not				
	listed on the M.A	A.R. She indicated she			What measures will be put in	to
	did not believe t	he blood pressures would			place or what systemic	
	be marked any p	place else.			changes you will make to ensure that the deficient	
					practice does not recur?	
	During the daily	conference on 8/22/12 at			p. dolloo dooo not reedi :	
		Director of Nursing was				
	•	unity to submit the July,				
	2012 M.A.R. an				Licensed nurses were re-educated b	,
		umentation demonstrating blood			the Staff Development Coordinator a Director of Nursing Services regarding	
		_			the monitoring of blood pressure	.9
	•	eart rates were checked in			parameters and following physician	
		ne if the medication			orders on August 28, 2012, and will continue to be educated ongoing.	
	should be held.				continue to be educated origining.	
	On 8/23/12 at 4:	00 P.M., the Director of			Disad was source as a remarkable for identity	isia d
	Nursing provide	d 3 pages of a M.A.R. for			Blood pressure parameters for ident residents have been added to the	illed
	July, 2012. The	order for the Metoprolol			resident's Medication Administration	
	was not listed or	n any of the three pages			Record.	
		Director of Nursing also				
	_	als Report" printout from				
	•	cords, listing blood			Nurses will document blood pressure	e
		in July and August, 2012.			results on the resident's Medication Administration Record, and administ	er
	pressures taken	in Jury and August, 2012.			medications per physician order. Th	
	D1 1 '	1 1			Unit Manager or designee will review	
	-	evels were documented			the Medication Administration every shift to ensure that blood pressures	
		15, 18, 19, 23, 24, and			were taken per physician orders.	
		lood pressures were				
	checked in the a	fternoon and evenings,				
	the earliest at 1:2	26 P.M. The other 3			How will the corrective	
	blood pressures	were checked in the			action(s) be monitored to	
	_	ne at 5:11 A.M., one at			ensure the deficient practice	
	•	the other at 11:50 A.M.			will not recur, i.e., what quali	
		5			Hot room, ho, what quali	⁷

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	of correction identification number: 155620	(X2) MULTIPLE CO A. BUILDING B. WING	00 	COMPLET 08/24/20	ED
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COI 675 S FORD RD ZIONSVILLE, IN 46077			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)	BE PRIATE	(X5) COMPLETION DATE
			assurance program will be into place? Medication Administration Records will be audited by managers for completion a documentation of blood premedication, daily x 30 days weekly x 4, monthly x 1, an quarterly x 3. The audits wireviewed by the CQI command should a threshold of 9 compliance not be met actiplans will be developed to e ongoing compliance.	nurse nd essure s, id III be hittee 95% on	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620			(X2) MULTIPLE A. BUILDING	E CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/24/2012
		155620	B. WING		00/24/2012
	ROVIDER OR SUPPLIER		675	ET ADDRESS, CITY, STATE, ZIP CODE S FORD RD NSVILLE, IN 46077	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=E	SPREAD, LINEN The facility must of Infection Control of provide a safe, sa environment and development and and infection. (a) Infection Control (b)	establish and maintain an Program designed to unitary and comfortable to help prevent the transmission of disease			
	Control Program (1) Investigates, of infections in the factions in the faction of the faction, should be resident; and (3) Maintains a recorrective actions	under which it - controls, and prevents acility; procedures, such as be applied to an individual cord of incidents and related to infections.			
	determines that a prevent the sprea must isolate the rice. (2) The facility must a communicable of lesions from direct their food, if direct disease. (3) The facility must their hands after of the spread of the	ction Control Program resident needs isolation to d of infection, the facility esident. ust prohibit employees with disease or infected skin et contact with residents or t contact will transmit the ust require staff to wash each direct resident contact ashing is indicated by			
	Personnel must he transport linens so of infection.	andle, store, process and o as to prevent the spread	E0441	F 444 Infoation Control	00/21/2012
		review and interview, the ensure that 2-step testing	F0441	F 441 Infection Control, Prevent Spread This provi	der 09/21/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		, DDIG	00	COMPLE	ETED
		155620		LDING		08/24/2	2012
			B. WIN		ADDRESS SITY STATE TIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
7101101	U L E NAE A BOVA/O				FORD RD		
ZIONSVI	ILLE MEADOWS			ZIONS	VILLE, IN 46077		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	for tuberculosis	(TB) was completed			establishes and maintains an		
	within 3 month	s prior to admission or			Infection Control Program		
		to the facility. This			designed to provide a safe,		
	1 *	ce affected 7 residents in a			sanitary and comfortable	4	
	_				environment and to help preventhe development and	ent	
	_	sidents reviewed.			transmission of disease and		
	,	#119, #139, #140, #153,			infection. What corrective	ve	
	#157, #158)				action(s) will be accomplished	_	
					for those residents found to		
	Findings includ	e:			have been affected by the		
					deficient practice? Reside	nts	
	1 The clinical	record of Resident #139			# 139, # 153, #119, #87 – The	е	
		n 8/21/12, at 10:38 A.M.			resident's 1 st and 2 nd step		
		· · · · · · · · · · · · · · · · · · ·			tuberculin testing has been		
		was admitted to the facility			initiated and will be completed		
		agnoses included, but were			timely. Residents # 140, # 1		
	not limited to, p	oressure ulcer- stage IV,			and # 158 no longer reside at		
	anxiety, depress	sive disorder, multiple			facility. How will you identi other residents having the	iy	
		neral vascular disease,			potential to be affected by th		
		ux, anemia of chronic			same deficient practice and		
	1 1	etures, weakness,			what corrective action will be	e	
	1				taken? All residents have the		
		rostomy, colostomy, and			potential to be affected by the		
	1	irst step TB skin test was			alleged deficient practice.		
		n 7/26/12 and was read on			Residents have a 2-step testir		
	7/30/12. There	was no documentation			for tuberculosis (TB) and may		
	that a first step	TB skin test was			completed within 3 months pri		
	administered pr	rior to or on 4/27/12.			to admission and upon admiss	sion	
	1				to the facility. The facility conducted an audit and any		
	2 The clinical	record of Resident #140			residents needing tuberculin		
		n 8/22/12, at 3:25 P.M.			testing were identified and PP	Ds I	
		· ·			have been placed and/or are i		
		was admitted to the facility			the process of continuing the		
		agnoses included, but were			series. What measures will	ı	
	not limited to, a	above knee amputation,			be put into place or what		
	chronic pain, ac	cute lung edema, diabetes			systemic changes you will		
	mellitus, history	y of gangrene, ischemic			make to ensure that the		
		nalnutrition vitamin D			deficient practice does not		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLETED
		155620	B. WING 08/24/2012			08/24/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				ORD RD	
ZIONSVI	LLE MEADOWS				VILLE, IN 46077	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	deficiency, hype	rlipidemia (elevated			recur? Licensed nurses wer	-
	cholesterol), dep	ressive disorder,			re-educated on the scheduling	
	hemiplegia (para	lysis of one side of the			and administration of resident	
	body), rheumatic	-			PPDs on August 28, 2012 by t	
					Staff Development Coordinato The facility conducted a TB	ſ.
		rtic valve), hypertension,			Testing Certification Class on	
	congestive heart	-			August 31, 2012, and Septeml	per
		disease. A first step TB			14, 2012, and will continue to	
		ninistered on 8/1/12, the			have opportunities for License	d
	day after admiss	ion, and was read on			Nurses to become and/or rema	
	8/3/12. There w	as no documentation that			PPD certified. Residents are)
	a first step TB sk	in test was administered			assessed upon admission for	
	prior to or on 7/3				PPDs. The 1 st Step PPD is given on date of admission, if it	not
	P				given prior to admission and th	
	3 The clinical r	ecord of Resident #153			charge nurse schedules the	
					necessary steps to complete the	ne
		8/21/12, at 9:25 A.M.			series. Annual PPDs have	
		as admitted to the facility			been scheduled, as needed.	
	on 7/12/12. Diag	gnoses included, but were			Nurse managers review the	
	not limited to, ap	phasia (difficulty with or			resident's hospital information	
	inability to speal	x), stroke, atrial			the day of admission to determ the date of the resident's 1 st	iirie
	fibrillation, histo	ry of hypertension,			Step PPD and schedules the	
		failure, bronchitis,			series, as necessary. Nurse	
		(shortness of breath),			managers review the resident's	
		lifficulty swallowing). A			medical record the day after th	e
		•			admission to the facility to ens	ure
	•	n test was administered			the 1 st Step PPD has been	
		ys after admission, and			administered and scheduled to	
		7/12. An order on the			read and the 2 nd Step series scheduled. The Director of	15
		nistration record (MAR)			Nursing Services or designee	will
	read, "Give 2nd	step PPD [tuberculosis			also run a report from the	
	skin test] 7/30/12	2 and read 8/2/12." There			Electronic Medical Record	
	was no indication	n a 2nd step TB skin test			monthly that will indicated any	
		d on 7/30/12. An			resident who does not have a	
		step" TB skin test was			current PPD documented.	
		8/12/12. There was no			The Director of Nursing Servic is responsible to ensure	es
					compliance with resident PPD	
	indication that the	ns test was read.			Compliance with resident FFD	i

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/24/2012
	PROVIDER OR SUPPLIER	675 S	ADDRESS, CITY, STATE, ZIP CODE FORD RD VILLE, IN 46077	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION DATE
	4. On 8/22/12 at 11:15 A.M., Resident #119's record was reviewed. Diagnoses included, but were not limited to, dementia, pain, dysphagia, and constipation. Resident #119 was admitted to the facility on 7/20/12. There was no documentation of an admission tuberculin skin test for Resident #119. An "Event Report," dated 8/12/2012, included but was not limited to, "Mantoux/PPD Documentation Date administered: 8/12/12 Type of Mantoux/PPD: 1st step Date read: 8/15/12: Negative 0 millimeters [induration]"		administration. How will to corrective action(s) be monitored to ensure the deficient practice will not rei.e., what quality assurance program will be put into plate A Resident Mantoux CQI to will be utilized daily x 30 day new admissions, weekly x 4, monthly x 2, and quarterly. The audits will be reviewed by the committee and should a three of 95% compliance not be maction plans will be developed ensure ongoing compliance.	ecur, ace? ool s on The e CQI shold et, ed to

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Facility ID: 000538

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		155620	B. WIN			08/24/2	012
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			DDRESS, CITY, STATE, ZIP CODE		
7101101/1	LLEMEADOWO				ORD RD		
ZIONSVI	LLE MEADOWS			ZIONSV	/ILLE, IN 46077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION (FACIL CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO TH		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	E APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)		TAG	BEIGHACI		DATE
		cumentation of a 2nd step					
	tuberculin skin t	est.					
	5 0 0 9/22/12 0	1.15 D.M. Davidant					
		t 1:15 P.M., Resident					
		cord was reviewed.					
	_	ded, but were not limited					
		ronary artery bypass					
		l infarction, and mild					
	nypoxic ischemi	c encephalopathy.					
	Dagidant #150 v	rea admitted to the facility					
	Resident #158 was admitted to the facility on 6/11/12 and discharged to a local						
		-					
	hospital on 6/15/	12.					
	There were no do	cumentation of an					
		culin skin test in Resident					
	#158's closed cli						
	#136 8 Closed Cli	ilicai record.					
	6 On 8/24/12 as	t 1:00 P.M., Resident					
		cord was reviewed.					
		ded, but were not limited					
	to, glioblastoma						
	io, giiooiustoillu	maniforme.					
	There was no do	cumentation of an					
		culin skin test in Resident					
	#157's closed cli						
		ecord for Resident #87					
		8/22/12 at 3:10 P.M.					
		nedical record indicated					
	the resident was						
		Alzheimer's unit on					
		gnoses of hypertension,					
		r disease, and chronic					
		onary disease. He was					
	Sobilactive pulli	ionary arocase. The was					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155620	B. WIN	IG		08/24/	2012
NAME OF I	PROVIDER OR SUPPLIER	· }			ADDRESS, CITY, STATE, ZIP CODE		
710110111	LLEMEADOWO				ORD RD		
ZIONSVI	LLE MEADOWS			ZIONSV	/ILLE, IN 46077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG			COMPLETION DATE
IAG		e Moving Forward		IAG			DATE
		· ·					
	rehabilitation unit on 5/23, then to a general population unit on 6/29/12. On						
	7/10/12, he retui						
		y Care secured/locked					
	unit.	,					
	An admission fi	rst and second step P.P.D.					
		derivative] tuberculin					
	skin test was not	t found in the paper or					
	electronic medic	eal record.					
		on 8/24/12 at 2:00 P.M.,					
		Nursing indicated the					
		lived in the Assisted					
	_	ial area, and had moved					
		t part of the facility. She					
		as unable to find any					
		of a P.P.D. skin test or					
	other tuberculos	is screen.					
	0 The feether						
	1	oolicy and procedure for ning-Tuberculosis" dated					
		ed, but was not limited to,					
	· · · · · · · · · · · · · · · · · · ·	idents, prior to or upon					
		be screened for TB					
	· · · · · · · · · · · · · · · · · · ·	accordance with state					
	and federal regu						
	On 8/24/12 at 5:	00 P.M., in an interview,					
		ed she was unable to					
		documentation of					
		esting for Residents #139,					
	140, 153, 157, 1	58, 119, and 87.					

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Event ID: W9GJ11

Facility ID: 000538

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PRINTED: 09/21/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620 A. BUILDING B. WING	COMPLETED 08/24/2012					
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS STREET ADDRESS, CITY, STATE, ZI 675 S FORD RD ZIONSVILLE, IN 46077						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF PROFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE PROFIX OF PROFIX PROFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE PROFIX OF PROFIX	ON SHOULD BE COMPLETION					
3.1-18(e)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W9GJ11

Facility ID: 000538

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155620	A. BUILDING B. WING		08/24/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	8		FORD RD	
ZIONSVII	LLE MEADOWS			VILLE, IN 46077	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0514	483.75(I)(1)				
F0514 SS=D	RES RECORDS-COM SSIBLE The facility must each resident in a professional stan are complete; acc readily accessible organized. The clinical recor information to ide of the resident's a care and services any preadmissior the State; and pro Based on intervi facility failed to accurate docume	maintain clinical records on accordance with accepted dards and practices that curately documented; e; and systematically d must contain sufficient entify the resident; a record assessments; the plan of a provided; the results of a screening conducted by the screening conducted by the service of the surface of the screening conducted by the s	F0514	F 514 Resident Records – Complete/Accurate/Accessit	
	-	ectronic health records for		This provider maintains clinical records on each resident in	11
	3 of 24 residents	reviewed. [Residents		accordance with accepted	
	#68, #81, and #8	89]		professional standards and practices that are complete; accurately documented; readi	lv
	Findings include	x:		accessible; and systematically organized.	· .
	1. In an intervie	w during the initial			
	orientation tour	on 8/20/12 at 10:55 A.M.,			
	L.P.N. #3 indica	ted Resident #68 would		The clinical record contains	
	frequently yell o	out and resist care.		sufficient information to identif the resident; a record of the	
	reviewed on 8/22 Diagnoses include	ord for Resident #68 was 2/12 at 3:30 P.M. ded, but were not limited tiaAlzheimer's type with ssive disorder,		resident's assessments; the p of care and services provided results of any preadmission screening conducted by the State; and progress notes.	

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Event ID: W9GJ11

Facility ID: 000538

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			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155620	B. WIN		·	08/24/2012	
NAME OF B	DROWNER OR GURRI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	C	675 S FORD RD				
	LLE MEADOWS			ZIONS	VILLE, IN 46077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
IAG		LSC IDENTIFYING INFORMATION)		TAG	DLI ICILIAC I)	DATE	
	osteoarthritis, and constipation.				What corrective action(s) will		
					be accomplished for those		
	_	ed electronic health record			residents found to have been		
		on of B.M.s indicated the			affected by the deficient		
	following:				practice?		
	5/15/12 to 5/20/	12: A B.M. was recorded					
	on 5/15, with the	e next one recorded on			Residents # 68, #81, #89 are		
	5/20/12. All oth	er entries between the			monitored daily for bowel		
	two dates were r	narked "none."			movements. The residents are	е	
					given laxatives, per physician		
	6/6/12 to 6/10/12	2: A B.M. was recorded			order, and bowel assessments		
	on 6/6, with the next one recorded on				are completed, as needed. The have been no negative outcome	I	
		er entries between the			related to resident bowel statu		
	two dates were r						
	6/21/12 to 6/26/	12: A B.M. was recorded			How will you identify other		
	on 6/21, with the	e next one recorded on			residents having the potentia	ni l	
		er entries between the			to be affected by the same		
	two dates were r	narked "none."			deficient practice and what		
					corrective action will be take	n?	
	6/26/12 to 6/30/	12: A B.M. was recorded					
		e next one recorded on					
	·	er entries between the			All residents have the potentia	l to	
	two dates were r				be affected by the alleged		
					deficient practice.		
	The electronic h	ealth record for "Events"					
	and " Progress N						
	documentation t				Resident bowel movements ar	e	
		stipation, abdominal pain,			documented in the electronic medical record by the Certified		
	_	stention during these			Nursing Assistant and/or	·	
	periods.	5 · · · · ·			Licensed nurse, each shift. Th	e	
	,				Licensed nurse runs a bowel		
	2. In an intervie	w during the initial			report, from the electronic		
			1			ĺ	

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Event ID: W9GJ11

Facility ID: 000538

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155620	B. WING		08/24/2012
NAME OF E	PROVIDER OR SUPPLIE		STREET	ADDRESS, CITY, STATE, ZIP CODE	•
NAME OF F	ROVIDER OR SUFFLIE	X.	675 S I	FORD RD	
ZIONSVI	LLE MEADOWS		ZIONS	VILLE, IN 46077	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	l `	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE
		on 8/20/12 at 10:35 A.M.,		medical record, for their speci unit at the beginning of their s	
		nted Resident #81 had		to trend the resident's bowel	
	_	ecline, and now used a		movements over the previous	7
		nobility due to being		days. The nurse utilizes this	
	unsteady during	ambulation.		report to determine if bowel	
				management protocol will be initiated.	
	The clinical record for Resident #81 was reviewed on 8/21/12 at 10:30 A.M. Diagnoses included, but were not limited to, senile dementia with delusions, hypertension, and osteoporosis. The resident had physician orders for Miralax routinely, and Milk of Magnesia as			initiated.	
				What measures will be put in	nto
				place or what systemic changes you will make to	
				ensure that the deficient	
				practice does not recur?	
	needed.	-			
	The computeriz	ed electronic health record		Licensed nurses and Certified Nurs	ing
	_	on of B.M.s indicated the		Assistants were re-educated by the	
	following:			Staff Development Coordinator and	I
				Director of Nursing Services regard documentation of bowel movements	ŭ .
	3/31/12 to 4/6/1	2: A B.M. was recorded		the electronic medical record on Au	~
		ext one recorded on		28, 2012, and education will continuous ongoing.	ie
	•	er entries between the two			
	dates were mark				
	dates were mark	ione.		Licensed nurses were reeducated b	nv
	4/8/12 to 4/11/1	2: A B.M. was recorded		the Staff Development Coordinator	*
		the next one recorded on		Director of Nursing Services regard	_
	· ·	her entries between the		the facility bowel management proto on Aug 28, 2012, and ongoing.	DCOI
	two dates were			, and angung.	
	two dates were	marked none.			
	5/10/12 to 5/25	12: A B.M. was recorded		The nurse managers run a bo	wel
				report per unit each morning	
	·	e next one recorded on		to clinical rounds. Any reside	I
	5/25/12. All other entries between the			found to not have a document	ted
	two dates were:	marked "none."		bowel movement in the previous	ous
				3 days will have the bowel	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	LDING	00	COMPLETED
		155620	B. WIN			08/24/2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R			ORD RD	
ZIONSVII	LLE MEADOWS				/ILLE, IN 46077	
					, , , , , , , , , , , , , , , , , , ,	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	The electronic h	nealth record for "Events"			protocol initiated. The unit	
	and " Progress 1	Notes" had no			manager, or designee, monito	rs
	documentation	that the resident			bowel protocol follow-up	
	experienced cor	nstipation, abdominal pain,				
	•	stention during these				
		stention during these			How will the corrective	
	periods.				action(s) be monitored to	
					ensure the deficient practice	
		ew during the initial			will not recur, i.e., what quali	
	orientation tour	on 8/20/12 at 10:35 A.M.,			assurance program will be p	-
	L.P.N. #3 indica	ated Resident #89 used a			into place?	
	wheelchair for mobility, with a self-release seat belt which the resident					
	was able to rele				The Device Climination COLLONINA	
	was able to fele	ase by ministri.			The Bowel Elimination CQI I will be utilized daily x 30, weekly x 4, mont	hlv x
					1, and quarterly to monitor compliar	
		ord for Resident #89 was			with bowel elimination. The audits will be reviewed by the CQI committee and should a threshold of 95% compliance not be met, action plans will be	•
	reviewed on 8/2	21/12 at 1:40 P.M.				
	Diagnoses inclu	ided, but were not limited				
	to, dementia, Pa	arkinson's disease, muscle			developed, to ensure ongoing	
	spasms, osteoar	thritis, and constipation.			compliance.	
	.	r				
	The computariz	ed electronic health record				
	•	ion of B.M.s indicated the				
		ion of B.M.s indicated the				
	following:					
	4/19/12 to 4/26/	12: A B.M. was recorded				
	on 4/19, with no	ext one recorded on				
	4/26/12. All otl	her entries between the				
	two dates were	marked "none." Progress				
		/12 to 4/26 indicated the				
	four quadrants and had no abdominal					
	Milk of Magnes	sia was given on 4/26/12.				
	resident had act four quadrants a distention. A P	ive bowel sounds in all and had no abdominal .R.N. [as needed] dose of				

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Event ID: W9GJ11

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155620	B. WIN	IG		08/24/	2012
NAME OF P	PROVIDER OR SUPPLIER	}	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					ORD RD		
ZIONSVI	LLE MEADOWS			ZIONS\	/ILLE, IN 46077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		12: A B.M. was recorded					
		e next one recorded on					
	6/20/12. All other entries between the						
		marked "none." The					
		record for "Events" and "					
	_	had no documentation					
	that the resident experienced constipation,						
	abdominal pain, or abdominal distention						
	during this period.						
	7/1/12 to 7/6/12: A B.M. was recorded on 7/1, with the next one recorded on						
	7/6/12. All othe	er entries between the two					
	dates were mark	ed "none." The electronic					
	health record for	r "Events" and " Progress					
	Notes" had no d	ocumentation that the					
	resident experie	nced constipation,					
	abdominal pain,	or abdominal distention					
	during this perio						
	7/15/12 to 7/22/	12: A B.M. was recorded					
	on 7/15, with the	e next one recorded on					
		ner entries between the					
		narked "none." The					
	electronic health	record for "Events" and "					
		had no documentation					
		experienced constipation,					
		or abdominal distention					
	during this perio						
	, and parie						
	In an interview of	during the daily					
		/22/12 at 4:15 P.M., the					
		sing indicated a report					
		was generated daily, and					
	101010 10 D.1VI.S	was generated daily, and					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620		LDING	00	COMPL 08/24/	ETED
	ROVIDER OR SUPPLIER	675 S F	ddress, city, state, zip code ORD RD /ILLE, IN 46077		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	reviewed during the daily rounds. If a resident had not had a B.M. in 3 days, the physician would be notified. She was given the opportunity to submit any documentation related to recording of bowel movements for Residents #68, #81, and #89. In an interview on 8/23/12 at 4:00 P.M., the Director of Nursing indicated she was not able to locate any ADL sheets with documentation of bowel movements. She suspected the information about B.M.s just didn't get documented due to occasional computer issues. 3.1-50(a)(1) 3.1-50(a)(2)				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIG	00	COMPL	ETED
		155620	A. BUII			08/24/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8					
ZIONOVII					ORD RD ILLE, IN 46077		
ZIONSVII	LLE MEADOWS			ZIONSV	71LLE, IN 46077		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F9999							
	STATE FINDINGS 3.1-14 PERSONNEL						
			F99	99			09/21/2012
					F9999 Personnel		
	(t)(1) At the time of employment, or				This provider ensures that at the time	e of	
	within one (1) month prior to				employment, or within one (1) month		
	` ′	•			prior to employment, and at least		
	1 2	d at least annually			annually thereafter, employees and non-paid personnel of the facilities sl	hall	
	_	oyees and nonpaid			be screened for tuberculosis. For		
	personnel of the facilities shall be screened for tuberculosis. For health care workers who have not had a documented				health care workers who have not ha		
					documented negative tuberculin skir test result during the preceding twelv		
					(12) months, the baseline tuberculin	/e	
		lin skin test result during			skin testing should employ the two-s	tep	
	_	relve (12) months, the			method. If the first step is negative,		
					second test should be performed one (1) to three (3) weeks after the first s		
		lin skin testing should			(1) to tinee (3) weeks after the mist s	icp.	
	1 0	step method. If the first					
	step is negative,	a second test should be					
	performed one (1) to three (3) weeks after			What corrective action(s) will	I	
	the first step.				be accomplished for those		
					residents found to have beer	1	
	This State Dule v	was not met as evidenced			affected by the deficient		
		was not met as evidenced			practice?		
	by:						
		ew and record review, the			Employees # 4, # 13, # 14, # 1	15.	
	facility failed to	ensure that 4 of 5 new			# 16, # 17, and # 18 - 1 st and		
	employees receiv	ved tuberculosis testing			2 nd Step PPDs and annual		
	by skin test or sc	ereen at or prior to hire;			PPDs are up to date.		
	_	olished employees					
		y annual skin test or					
	_	,					
		yees #4, #13, #14, #15,			How will you identify other		
	#16, #17, and #1	8]			residents having the potentia	ai	
					to be affected by the same		
	Findings include	: :			deficient practice and what	0	
					corrective action will be take	n?	

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Event ID: W9GJ11

Facility ID: 000538

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155620	B. WIN	G		08/24/2012
NAME OF P	ROVIDER OR SUPPLIER	- -			ADDRESS, CITY, STATE, ZIP CODE	
	= = . =				ORD RD	
ZIONSVI	LLE MEADOWS			ZIONS\	/ILLE, IN 46077	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Following the er	ntrance conference on				
	8/20/12, the Executive Director provided a completed "Employee Records" forms				All employees have the potent	ial
					to be affected by the alleged	
	-	0], listing all employees			deficient practice.	
	currently working	ng in the facility.				
	Five new hire employees, and 10 established employees, were randomly				Employees have a 2-step testi	ng
					for tuberculosis (TB) upon hire	
	selected for file review. The personnel files for 4 new hires and 3 established employees had no documentation of first				and annual, if applicable.	
		ep, or timely annual			The facility conducted an audit	
	P.P.D. [Purified	Protein Derivative] skin			and any employees needing tuberculin testing were identified	ad
	tests, or other sc	reens as follows:			and PPDs have been placed	su
					and/or are in the process of	
	· ·	th date of hire 8/1/12: A			continuing the series.	
	•	skin test was given on				
		l on 8/2/12. A second				
	•	found. There was no			What measures will be put in	to
		hat the employee had a			place or what systemic	
	_	in the preceding 12			changes you will make to ensure that the deficient	
	months.				practice does not recur	
	D GM 4 114.5	.4 1 . 01:				
	•	with a date of hire				
		and second step test was			The facility conducted a TB	
	not found.				Testing Certification Class on	
	C CN A H1C				August 31, 2012, and Septeml	per
	C. C.N.A. #16, with a date of hire 7/11/12: There was a copy of				14, 2012, and will continue to	.
					have opportunities for License Nurses to become or remain F	
		of a positive P.P.D. done			certified.	
	•	on 8/8/11, with a chest-ray done on				
	8/11/11, at some other location.					
	Documentation (of a tuberculosis screen				

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		155620	B. WIN			08/24/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	₹			ORD RD	
	LLE MEADOWS			ZIONS\	VILLE, IN 46077	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)	+	TAG	New hires are administered th	DATE
		ompleted at, or prior to,			st Step PPD, prior to hire, and	
		ionsville Meadows was			annually.	
	not found.					
	· ·	ith a date of hire 4/11/12:			Employee annual PPDs have	
		as identified on the			been scheduled, as needed.	
	1 2	ords" form as being a				
	positive reactor	to a P.P.D. test, date				
	unknown. A ch	est x-ray was documented			T. 0. 55	
	as done on 4/23/12, and was negative for				The Staff Development has created a calendar to track	
	active disease.				employee second step and	
				annual PPD due dates.		
	E. Housekeeper	#17, with a date of hire			The Staff Development	
	2/9/11: A tuber	culosis screen and chest				
	X-ray was found	d for the date of hire on				
	2/11/11. A curr	ent annual screen, due in			Coordinator is responsible for	
	February, 2012,	was not found.			compliance with employee PP	Ds.
		ee #4, with a re-hire date				
		annual P.P.D. was			How will the corrective	
	completed late of	on 7/16/12.			action(s) be monitored to	
					ensure the deficient practice	
		istant #18, with a hire			will not recur, i.e., what quali assurance program will be p	-
		The annual P.P.D. was			into place?	
	completed late of	on 7/9/12.			,	
	In an intermi-	duming the deiler				
	In an interview	•			The Personnel File audit tool v	vill
		/22/12 at 4:15 P.M., the			be utilized for new hires month	nly
	Director of Nursing indicated she had				to review 1 st and 2 nd step	ND ₀
		olem with tuberculosis			PPDs. Employee's annual PP will be administered on the sal	
	testing for both residents and employees				month each year and audited	
	-	rough the facility's			months. The audits will be	
		ce program. She had	reviewed by the CQ		reviewed by the CQI committee	
	initiated an action plan during that month,				and should a threshold of 95%	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W9GJ11

Facility ID: 000538

If continuation sheet Page 43 of 60

PRINTED: 09/21/2012 FORM APPROVED OMB NO. 0938-0391

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155620	B. WIN			08/24/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		675 S FORD RD				
ZIONSVII	LLE MEADOWS		ZIONSVILLE, IN 46077				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	and those employ	yees and residents who			compliance not be met action		
	did not have initial, or current, skin tests or screens were re-tested. 3.1-14(t)(1)				plans will be developed to ens	ure	
					ongoing compliance.		
R0000							
	These State Resi	dential findings are cited	R0000				
		ith 410 IAC 16.2-5	1100		The creation and submission of this plan of correction does not		
	in accordance wi	m 410 Me 10.2 3					
					constitute an admission by this		
					provider of any conclusion set		
					forth in the statement of		
					deficiencies, or of any violation	n of	
					regulation.		
					This provider respectfully		
					requests that the 2567 plan of		
					correction be considered as th		
					letter of credible allegation and		
					request a desk review on or a September 23, 2012.	itei	
					Coptember 25, 2012.		

State Form Event ID: W9GJ11 Facility ID: 000538 If continuation sheet Page 44 of 60

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155620	B. WING			08/24/	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t e e e e e e e e e e e e e e e e e e e			ORD RD		
ZIONSVII	LLE MEADOWS				/ILLE, IN 46077		
					71222, 114 10077	-	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0092	410 IAC 16.2-5-1						
	Administration an	id Management -					
	Noncompliance	at maintain a written fire					
	(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the						
	transmission of a fire alarm signal and						
		ergency fire conditions,					
	•	ovement of nonambulatory					
	residents to safe areas or to the exterior of						
	the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals						
		action required under varied					
	• •	st twelve (12) drills shall be					
		When drills are conducted					
		nd 6 a.m., a coded					
	·	ay be used instead of					
	audible alarms.						
		six (6) months, a facility					
		old the fire and disaster					
	•	n with the local fire					
	•	cord of all training and drills nted with the names and					
		personnel present.					
	-	review and interview, the	R00	92	D 002 1) What corrective		09/21/2012
		-	100	<i>)</i> <u></u>	R 092 1) What corrective action(s) will be accomplishe	d	07/21/2012
	•	ensure that it attempted			for those residents found to	u	
		s in conjunction with the			have been affected by the		
	•	ment at least every 6			deficient practice: Administra	tor	
	months.				met with local Fire Marshall an		
					Captain on September 7, 2012		
	Findings include	::			discuss the need for conducting	g	
	6				joint fire drills and staff educati		
	On 8/20/12 at as	ntrance conference at			Fire Marshall indicated that he		
	•				would like to review facility's fir		
		Executive Director (E.D.)			plan and then would contact the		
		Nursing (DON) were			Administrator to schedule the figorial joint fire drill. 2) How the faci		
	asked to provide	documentation of			will identify other residents	ııty	
					will identify other residents		

State Form Event ID: W9GJ11 Facility ID: 000538 If continuation sheet Page 45 of 60

	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/24/2012
	PROVIDER OR SUPPLIER LLE MEADOWS	675 S F	ORD RD /ILLE, IN 46077	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	completed fire drills for the previous one year period. On 8/24/12 at 11:30 A.M., the documentation of fire drills was reviewed. There was no indication that the local fire department had participated in any of the completed fire drills reviewed. The E.D. and DON were asked to provide any additional documentation they had regarding fire drills done in coordination with the local fire department. In an interview on 8/24/12, at 12:00 P.M., the E.D. and DON were asked if they had any additional documentation regarding coordination of fire drills with the local fire department. They indicated they had not been aware they were required to coordinate fire drills with the local fire department. No additional documentation was provided.		having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to affected. Fire drills will be held quarterly on all three shifts an minimum of twice per year in conjunction with the Fire Department 3) What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Joint fire drills and staff education will be set on a rout schedule and will be document in the maintenance monthly find drill schedule book that is kep the maintenance office. 4) He the corrective action(s) will the monitored to ensure the deficient practice will not recipe. What quality assurance program will be put into place. The maintenance Director will responsible to ensure that the local fire department are calle and scheduled to be at the fact at the time of the fire drill. Fact Administrator or designee will review all fire drill documentat quarterly to ensure proper dril and education was conducted.	be d d a res t ine ine ine ited re t in ow oe cur, ee: be d d cility ility ion is

State Form Event ID: W9GJ11 Facility ID: 000538 If continuation sheet Page 46 of 60

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	JETIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
ANDILAN	of correction	155620	A. BUIL	DING	00	08/24/	
		133020	B. WIN			00/24/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ZIONSVI	LLE MEADOWS				ORD RD /ILLE, IN 46077		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0148	(e) The facility shard grounds, and equicondition, in good that may adverse welfare of the resifollows: (1) Each facility slimplement a writter maintenance to elupkeep of the facility slimplement a writter maintenance to elupkeep of the facility. The electrical appliances, cords sources, fire alarm shall be maintained functioning and conclude electrical codes. (3) All plumbing somply with state (4) At least yearly systems shall be assed on observed record review, the sharp items were residents. This dipotential to affect resided on the "Colocked/secured Alunit) who ambulated on 8/23/12, at 10 general environmer residential/assistation.	affety Standards - Deficiency all maintain buildings, ipment in a clean repair, and free of hazards by affect the health and idents or the public as shall establish and en program for insure the continued ility. System, including systems, ed to guarantee safe compliance with state shall function properly and plumbing codes. The heating and ventilating inspected. The facility failed to ensure azardous chemicals and enot accessible to deficient practice had the state of 21 residents who cottage 1" unit (a Alzheimer's/dementia ated independently.	R01	48	R 148 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All identified hazards were immediately removed and secured. 2) How the facility will identify other residents having the potentiat to be affected by the same deficien practice and what corrective action will be taken: All residents on cottage 1 have the potential to be affected. Nursing staff will monitor resident areas to ensure all hazardous materials and sharps are	l t	09/21/2012

State Form Event ID: W9GJ11 Facility ID: 000538 If continuation sheet Page 47 of 60

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155620	B. WIN			08/24/	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ORD RD		
ZIONSVI	LLE MEADOWS				/ILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Executive Direct	tor, the Maintenance			properly secured. All staff have		
	Supervisor, the I	Laundry/Housekeeping			been re-educated on proper storage	2	
	Supervisor, and the Memory Care				of chemicals and other hazardous		
	Facilitator in attendance.				materials by the Staff Development		
		endance.			Coordinator and Memory Care		
	0 0/22/12 11	0.50 4.35 1.41			Coordinator on August 28 th .		
	1	0:50 A.M., a bathroom in					
	1	to the nurse's station was			3) What measures will be put into		
	found to be unlo	cked and to contain a			place or what systemic changes the		
	plastic container	labeled "Sani-Cloth			facility will make to ensure that the deficient practice does not recur:	:	
	Germicidal Disposable Wipe." The label				Maintenance Director and Assistant		
	indicated, "Hazard to human and				Administrator shall make rounds		
	domestic animals " "Caution: causes				daily to ensure that all hazardous		
	moderate eye irritation. Harmful if				materials are stored behind a locked	i	
	1				door or cabinet. All locks will be		
	1	h skin. Avoid contact			checked to ensure proper		
	1	or clothing" "First aid:			functionality. All findings will be		
	1	eye open and rinse			corrected immediately		
	slowly. If on sk	in or clothing, take off					
	contaminated clo	othing. Rinse skin			4) How the corrective action(s) will	1	
	immediately wit	h plenty of water for			be monitored to ensure the		
	15-20 minutes. (Call a poison control			deficient practice will not recur, i.e.	•	
		for treatment advice."			what quality assurance program		
		Tot troumont advice.			will be put into place. The Care		
	Also found in th	is same bathroom was a			Rep Daily rounds Checklist wil utilized on the unit daily x 30	ı be	
					days, monthly x 2 and quarterl	v x	
		"Array perineal wash"			3. The audits will be reviewed		
		indicated, "Keep out of			the CQI committee and should		
	reach of children	n. For external use only."			threshold of 95% compliance r	not	
					be met, action plans will be		
	Also found in th	is same bathroom were			developed to ensure ongoing		
	two 8.5 ounce be	ottles of "McKesson			compliance.		
	Wash for Hair and Body." The labels of each bottle indicated this product was for "External use only. Discontinue if						
	irritation occurs. Avoid contact with						
	eyes. In case of	eye contact flush with					

State Form Event ID: W9GJ11 Facility ID: 000538 If continuation sheet Page 48 of 60

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	00	COMPLETED		
		155620	A. BUILDING B. WING		- 08/2	4/2012
	PROVIDER OR SUPPLIEF		675 S F	ADDRESS, CITY, STATE, ZIP C ORD RD /ILLE, IN 46077	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
		et a physician." One ved to be full, and one be 1/2 full.				
	11 ounce can of shaving cream" "Contents under reach of childrer On 8/23/12 at 1 dining room/acti In the center of t with a sink enclocabinets extending angle from the we cabinets facing t	is same bathroom was an "McKesson Medi-Pak with a label indicating, pressure. Keep out of a." 1:10 A.M., the Cottage 1 vity area was observed. his area was a kitchenette osed in one row of an outward at a right vall, and another row of the sink and this first row the right side, across				
	from the sink, a contain a pair of rounded end.	drawer was found to metal scissors with a w of cabinets, another				
	drawer was foun	d to contain a al "toenail clipper" with a				
	drawers. The bootserved to cont clipper with a po	were observed three oftom drawer was ain a metal, folding nail ointed file that could be I out to the side of the				

State Form Event ID: W9GJ11 Facility ID: 000538 If continuation sheet Page 49 of 60

PRINTED: 09/21/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155620		ILDING	00	COMPL 08/24/	ETED
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	1 dining room ol	at the time of the Cottage observation, the Memory indicated he would secure					

State Form Event ID: W9GJ11 Facility ID: 000538 If continuation sheet Page 50 of 60

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JETIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED 08/24/2012	
		155620	B. WIN	G		08/24/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ORD RD		
ZIONSVII	LE MEADOWS			ZIONS\	/ILLE, IN 46077		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0217	410 IAC 16.2-5-2						
	Evaluation - Defic						
		pletion of an evaluation, appropriately trained staff					
		lentify and document the					
		ovided by the facility, as					
	follows:	, , , , , , , , , , , , , , , , , , ,					
	(1) The services of	offered to the individual					
		appropriate to the:					
	(A) scope;						
	(B) frequency;						
	(C) need; and (D) preference;						
	of the resident.						
	(2) The services of	offered shall be reviewed					
	and revised as ap	propriate and discussed by					
		acility as needs or desires					
	-	e facility or the resident					
	may request a se						
		oon service plan shall be by the resident, and a					
		e plan shall be given to the					
	resident upon req						
		on and documentation of					
	services provided	is needed if evaluations					
	•	e initial evaluation indicate					
	no need for a cha	_					
	· ·	on of medications or the					
		ential nursing services, or a licensed nurse shall be					
		ication and documentation					
	of the services to						
		review and interview, the	R02	17	R217 1) What corrective		09/21/2012
		obtain a signature from			action(s) will be accomplishe	d	
	•	ne agreed upon service			for those residents found to		
		ent practice affected 4 of			have been affected by the		
	•	wed. [Residents #10, 69,			deficient practice: Residents		
		wed. [Residents #10, 09,			#10, #69, and #50 service plan	ıs	
	50, and 201].				have been updated and signatures of responsible partic	00	
					obtained. Resident #201 no	ರತ	
	Findings include	:			longer resides at the facility 2)	
			1		<u> </u>		

State Form Event ID: W9GJ11 Facility ID: 000538 If continuation sheet Page 51 of 60

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155620	B. WIN			08/24/2012
			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	R.		675 S F	ORD RD	
ZIONSVI	LLE MEADOWS			ZIONS\	VILLE, IN 46077	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	MANUFACTOR IN AN OF CONDUCTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
					How the facility will identify	
	1 On 8/23/12 a	t 2:05 P.M., Resident			other residents having the	
		·			potential to be affected by th	e
		reviewed. Diagnoses			same deficient practice and	
	1	ere not limited to,			what corrective action will be	
		entia, agitation, and			taken: An audit of all current	
	history of alcoho	ol dependence and abuse.			residents' service plans was	
					conducted. All residents with	
	A "Service Plan	for Residential Care,"			current service plans found to	
		id not have a resident			have a signature from either the resident or the responsible particle.	
signature.				have been contacted and aske	,	
	Signature.				to sign the service plan. 3)	
	, ua : ъ	0 0 11 110 11			What measures will be put in	to
		for Residential Care,"			place or what systemic	
	dated 7/26/12, d	id not have a resident			changes the facility will make	e
	signature.				to ensure that the deficient	
					practice does not recur: Fac	ility
	2. On 8/24/12 a	t 10:10 A.M., Resident			representative will complete	
		reviewed. Diagnoses			service plans with alert and	
		ere not limited to,			oriented resident in a face to fa meeting. If resident is not aler	
	-	owel disease and gastritis.			and oriented or refuses to assi	
		wer disease and gastritis.			in completion of their service	
	A IIC DI	Companiation of the state of th			plan, a phone call will be place	ed
		for Residential Care,"			to resident's responsible party	
	1	s signed by the resident;			offering a time to come into	
	however, the ser	ni-annual service plan,			facility to discuss the new serv	rice
	dated 3/21/12, w	as not signed by the			plan. If residents responsible	.bla
	resident.				party refuses to meet or is una	
					to come to the facility to discus service plan, a copy will be ma	
	3 On 8/24/12 a	t 10:28 A.M., Resident			to them with a self addressed	Anou
		s reviewed. Diagnoses			stamped envelope so that they	,
		· ·			can review, sign, and return to	•
	1	ere not limited to, diabetes			facility. Resident service plan	
	mellitus.				completed during the previous	
					week, including new admission	
	A "Service Plan	for Residential Care,"			semi annual assessments, and	d
	dated 3/16/12, w	as not signed by the			residents with a change of condition, will be reviewed dur	ing
	resident.	2 ,			the weekly at- risk meeting to	III'Y
					LIC WEEKIY AL- HISK ITIEELING LO	

State Form Event ID: W9GJ11 Facility ID: 000538 If continuation sheet Page 52 of 60

	OF CORRECTION IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/24/2012		
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	4. On 8/24/12 at 10:55 A.M., Resident #201's closed clinical record was reviewed. Diagnoses included, but were not limited to, dementia with agitation. A "Service Plan for Residential Care," dated 1/19/12, was not signed by the resident's legal representative. 5. In an interview on 8/24/12 at 11:15 A.M., LPN #5 indicated she was aware all agreed upon service plans required either the resident's signature or the resident's legal representative.		assure that the proper signatule have been obtained. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not redice. What quality assurance program will be put into place Service plans will be monitored and audits completed monthly Assistant Administrator, in addition to the weekly reviewed during at-risk meetings. Audit will be reviewed monthly by the CQI committee and should a threshold of 95% compliance be met, action plans will be developed to ensure ongoing compliance.	ee. d by by ss ee		

State Form Event ID: W9GJ11 Facility ID: 000538 If continuation sheet Page 53 of 60

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLE			ETED	
		155620				08/24/	2012
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
7101101/11	1 E MEADOWO				FORD RD		
ZIONSVII	LE MEADOWS			ZIONS	VILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	12	DATE
R0304	410 IAC 16.2-5-6	(e)				•	
	Pharmaceutical S	Services - Deficiency					
	(e) Medicine or tre	eatment cabinets or rooms					
		ately locked at all times					
	•	orized personnel are					
	•	dule II drugs administered					
		Il be kept in individual					
		double lock and stored in a					
	mobile drug stora	structed box, cabinet, or ge unit.					
	Based on observa	ation and interview, the	R03	04			09/21/2012
	facility failed to	ensure 1 of 2 medication			R304		
	carts were not le	ft unlocked or			1) 14/hat agus ation action/a) will be		
	unsupervised. T	his deficient practice had			1) What corrective action(s) will be	2	
	the potential to a	ffect 64 of 85 residents			accomplished for those residents		
	•	on-locked/secured			found to have been affected by the	1	
	residential care u				deficient practice: LPN #2 was re-educated on locking the		
	residential care u	IIIIt.			medication cart at all times and not		
					meeting these standards of		
	Findings include	:			practice. The medication cart was		
					secured immediately and there wer	0	
	On 8/21/12 at 11	:30 A.M., medication			no negative resident outcomes.	C	
	pass was observe	ed with Licensed					
	Practical Nurse [LPN] #2.			2) How the facility will identify		
					other residents having the potentia		
	At 11:45 A.M I	LPN #2 left a medication			to be affected by the same deficien		
		unlocked, and with her			practice and what corrective action		
		ng on top of the cart, in			will be taken: All residents have the		
		•			potential to be affected. Employees		
	•	resident rooms. In			were in-serviced on August 28, 2012	2,	
	addition, two ele	vators were located near			and ongoing by the Staff		
	the unattended m	nedication cart.			Development Coordinator, or		
					designee, on standards of practice,		
	From 11:45 A M	I. to 12:00 P.M., LPN #2			i.e., insuring all medication or		
		sight of the unlocked			treatment cabinets, carts, or med		
		Residents were observed			rooms will be locked at all times		
					unless attended to by an associate		
	passing the cart of	on their way to lunch.			with privileges allowing them to		
					have access to those areas.		

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	OF CORRECTION	IDENTIFICATION NUMBER: 155620	A. BUILDING B. WING	00	COMPLETED 08/24/2012		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	indicated she did left unlocked wit unattended.	n an interview, LPN #2 n't realize the cart was th her facility keys left N #2 locked the cart and s.		Department supervisors monitor medication carts/rooms daily to ensure they are secured. 3) What measures will be put into place or what systemic changes th facility will make to ensure that th deficient practice does not recur: Clinical Director or designee will audit med carts and med rooms to ensure that they are being kept locked at all times when a clinical staff is not present.	e		
				4) How the corrective action will be monitored to ensure deficient practice will not recise. what quality assurance program will be put into place Audits will be conducted daily weeks, weekly X 2 months, an quarterly X3. Findings from the audits will be reviewed at mor CQI meeting and should a threshold of 95% compliance be met corrective action plans be implemented to ensure ongoing compliance.	the cur, ce X 4 and anese anthly		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		155620	B. WIN	G		08/24/	2012
ZIONSVII	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077		(X5)		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
	*				CROSS-REFERENCED TO THE APPROPRIAT	ΓE	
PREFIX TAG R0408	A "Resident #69 wa on 9/15/11. A "Resident #69 wa on 9/15/11. A "Resident Imm History Form" ir limited to , "Che 9/22/11. On 8/24/12 at 11 indicated she wa have a chest x-ray takent in facility. On 8/24/12 at 5:	- Noncompliance shall have a diagnostic leted no more than six (6) dmission. ation and interview, the obtain a resident's chest mission to the facility. actice affected 1 of 7 ed for admission chest at #69] d: b:10 A.M., Resident #69's wed. Diagnoses re not limited to, wel disease and gastritis. s admitted to the facility nunization and Health heluded, but was not st x-ray: [completed on] :15 A.M., LPN #5 s aware residents must by prior to admission to	R04	PREFIX TAG	R408 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 69 admission chest x-ray was located and present on medical record. 2) How the facility will identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taken:The facility conducted an audit and any residents needing a chest x-ray were identified and chest x-ray have been obtained. 3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Leasing Director has been in-serviced on the policy to have a documented chest x-ray on all new residents. Clinical Director or designee will review all admission paperwork prior to admission to ensure a chest x-ray has been obtained.	ıl t	O9/21/2012
	Nursing was una documentation o	able to provide f an admission chest			How the corrective action(s) will be monitored to ensure the		

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	OF CORRECTION	IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED - 08/24/2012			
	PROVIDER OR SUPPLIEF	<u>I</u>	STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION			
	x-ray for Reside	nt #69.		deficient practice will not re what quality assurance prowill be put into place. Assis Administrator will audit all radmission paperwork weeklensure chest x-rays were obprior to admission. Findings these audits will be reviewe monthly CQI meeting and sthreshold of 95% compliancemet, corrective action plans implemented to ensure ong compliance.	gram stant new AL ly to stained s from d at nould a se not be s will be			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620		A. BUII	DING	NSTRUCTION 00	(X3) DATE : COMPL 08/24 /	ETED	
		100020	B. WIN			00/24/	2012
	PROVIDER OR SUPPLIER			675 S F	ADDRESS, CITY, STATE, ZIP CODE ORD RD /ILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
R0410	completed within admission or upo forty-eight (48) to The result shall be induration with the and by whom adrest (f) For residents with documented negative result during the properties of the performed with weeks after the five repeat testing will infection with tube (g) All residents with the total total to have a chest will laboratory examinate a diagnosis. Based on record facility failed to testing as required admission or any practice affected for required tube [Residents #10 at #10's record was included, but we included, but we included, but we included in the same properties of the same properties at the same properties affected for required tube and the same properties are same properties.	- Noncompliance tuberculin skin test shall be three (3) months prior to n admission and read at seventy-two (72) hours. The recorded in millimeters of e date given, date read, ministered and read. Who have not had a stive tuberculin skin test preceding twelve (12) line tuberculin skin test preceding twelve (12) line tuberculin skin testing the two-step method. If the sive, a second test should min one (1) to three (3) rest test. The frequency of a depend on the risk of erculosis. Who have a positive reaction skin test shall be required read and other physical and mations in order to complete review and interview, the perform tuberculin skin test deto residents on anally. This deficient 2 of 7 residents reviewed erculin skin testing. Ind #69]	R04	10	What corrective action(s) we accomplished for those residents found to have been affected by the deficient practice? Residents # 69, # — The resident's 1 st and 2 nd step tuberculin testing has been initiated and will be completed timely. How will you identify other residents having the potential to be affected by the same deficient practice a what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. Residents have a 2-step testing for tuberculosis (TB) and may	t 10 t 10 en ng y nd ene	09/21/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING		COMPL	ETED
		155620	B. WIN			08/24/	2012
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8		675 S FORD RD			
ZIONSVI	LLE MEADOWS			ZIONSVILLE, IN 46077			
(VA) ID	CIDOLADVO	TATEMENT OF DEPICIENCIES			, I	ı	(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
TAG	`	ICY MUST BE PRECEDED BY FULL		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG			DATE
					completed within 3 months price to admission and upon admiss		
	A "Resident Imr	nunization and Health			to the facility. The facility	1011	
	History Form" ii	ncluded, but was not			conducted an audit and any		
	limited to, "Man	toux Tests [tuberculin			residents needing tuberculin		
	skin testingl: 8/	16/10 and 4/18/12 [both			testing were identified and PPI	Os	
		meters or negative].			have been placed and/or are in	า	
	1 Courts as 6 mini	meters of negative].			the process of continuing the		
	mi i				series. What measures will		
	There was no documentation of tuberculin skin testing in 2011.				be put into place or what		
					systemic changes you will		
				make to ensure that the			
	2. On 8/24/12 at 10:10 A.M., Resident				deficient practice does not		
#69's record was reviewed. Diagnoses				recur? Licensed nurses wer			
		ere not limited to,			re-educated on the scheduling		
		owel disease and gastritis.			and administration of resident PPDs on August 28, 2012 by t	ho	
		ower disease and gastitus.			Staff Development Coordinato		
					The facility conducted a TB		
	Resident #69 wa	as admitted on 9/15/11.			Testing Certification Class on		
					August 31, 2012, and Septemb	per	
	A "Resident Imr	nunization and Health			14, 2012, and will continue to		
	History Form" ii	ncluded, but was not			have opportunities for License		
		toux tests: 9/30/11			Nurses to become and/or rema		
	ĺ ,	with millimeter results	PPD certified. Residents are				
		with infillificter results			assessed upon admission for		
	[negative]"				PPDs. The 1 st Step PPD is given on date of admission, if r	not	
					given prior to admission and th		
	There was no do	ecumentation of an			charge nurse schedules the		
	admission tubero	culin skin test.			necessary steps to complete the	ne l	
					series. Annual PPDs have		
	On 8/24/12 at 12	2:00 P.M., in an			been scheduled, as needed.		
		irector of Nursing			Nurse managers review the		
	· ·	I not have any other			resident's hospital information		
		•			the day of admission to determ	nine	
		or the tuberculin skin			the date of the resident's 1 st		
	_	lents #10 and #69. She			Step PPD and schedules the		
	indicated that a p	problem with tuberculin			series, as necessary. Nurse managers review the resident's		
	skin testing was	identified by the facility			medical record the day after th		
	in May 2012.	, , ,			admission to the facility to ensi		
						-	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/24/2012
	PROVIDER OR SUPPLIE	R	STREET A 675 S F	ADDRESS, CITY, STATE, ZIP CODE FORD RD VILLE, IN 46077	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
				the 1 st Step PPD has been administered and scheduled read and the 2 nd Step series scheduled. The Director of Nursing Services or designer also run a report from the Electronic Medical Record monthly that will indicated arresident who does not have current PPD documented. The Director of Nursing Services responsible to ensure compliance with resident PP administration. How will the corrective action(s) be monitored to ensure the deficient practice will not refie., what quality assurance program will be put into plate. A Resident Mantoux CQI to will be utilized daily x 30 day new admissions, weekly x 4, monthly x 2, and quarterly audits will be reviewed by the committee and should a three of 95% compliance not be maction plans will be developed ensure ongoing compliance.	s is f e will ny a rices D he ecur, ace? ool s on The e CQI shold et, ed to

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